



April Medical Care Advisory Committee Meeting

April 27, 2022



Today's Agenda



- ▶ Call to Order
- ▶ Special Budget Hearing Presentation Continuation: Medicaid Program Overview
- ▶ Unwinding PHE Presentation and Discussion
- ▶ Subcommittee Updates
- ▶ Opportunity for Public Comment
- ▶ Announcements
- ▶ Adjournment



SPECIAL MCAC BUDGET PRESENTATION CONTINUATION: MEDICAID PROGRAM OVERVIEW

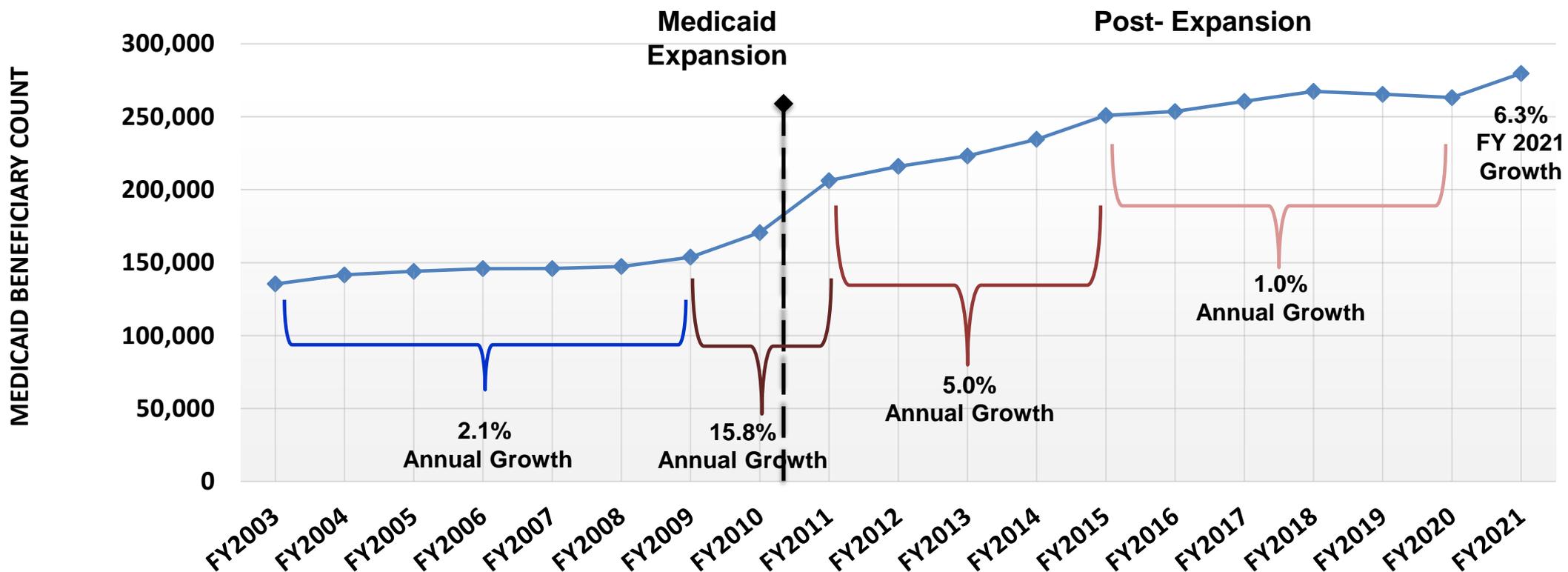
Presentation Overview

- ~~Overview Of District's Budget For FY2023~~
- ~~Overview of Deputy Mayor, Human Support Services Cluster Priorities~~
- ~~Cedar Hill Regional Medical Center Progress~~
- ~~DHCF Program Overview~~
- ~~DHCF Budget Development and Rates~~
- ~~Building Infrastructure to Support Program Value & Accountability~~
 - ~~DC Access System Eligibility System~~
 - ~~Health Information Exchange~~

- Medicaid Program Overview**
 - Eligibility
 - Enrollment
 - Utilization and Spending Trends
- Medicaid Program Trends**
 - Medicaid Managed Care
 - Pharmacy
 - Behavioral Health
 - Long-Term Care
- Alliance**
- Conclusion**

Medicaid Enrollment Is Highest It Has Ever Been

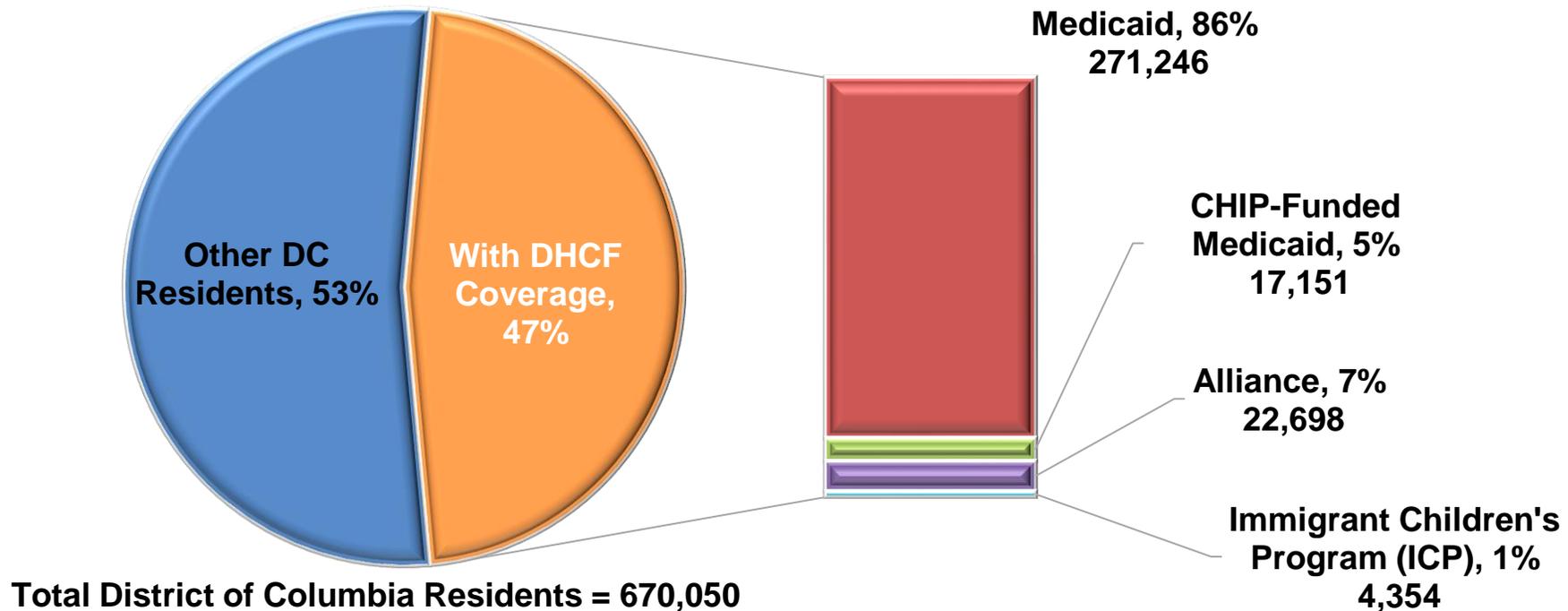
Medicaid Enrollment Trends, FY 2003 to FY 2021



Source: Data for FYs 2000-2009 extracted by Xerox from tape back-ups in January 2010. Data for FYs 2010-2020 from DHCF's Medicaid Management Information System as of March 2022. Figures are average monthly.

Nearly Half of District Residents Rely on DHCF-Funded Health Care Coverage – Most in Medicaid

Proportion of DC Residents with DHCF-Funded Coverage, FY 2021

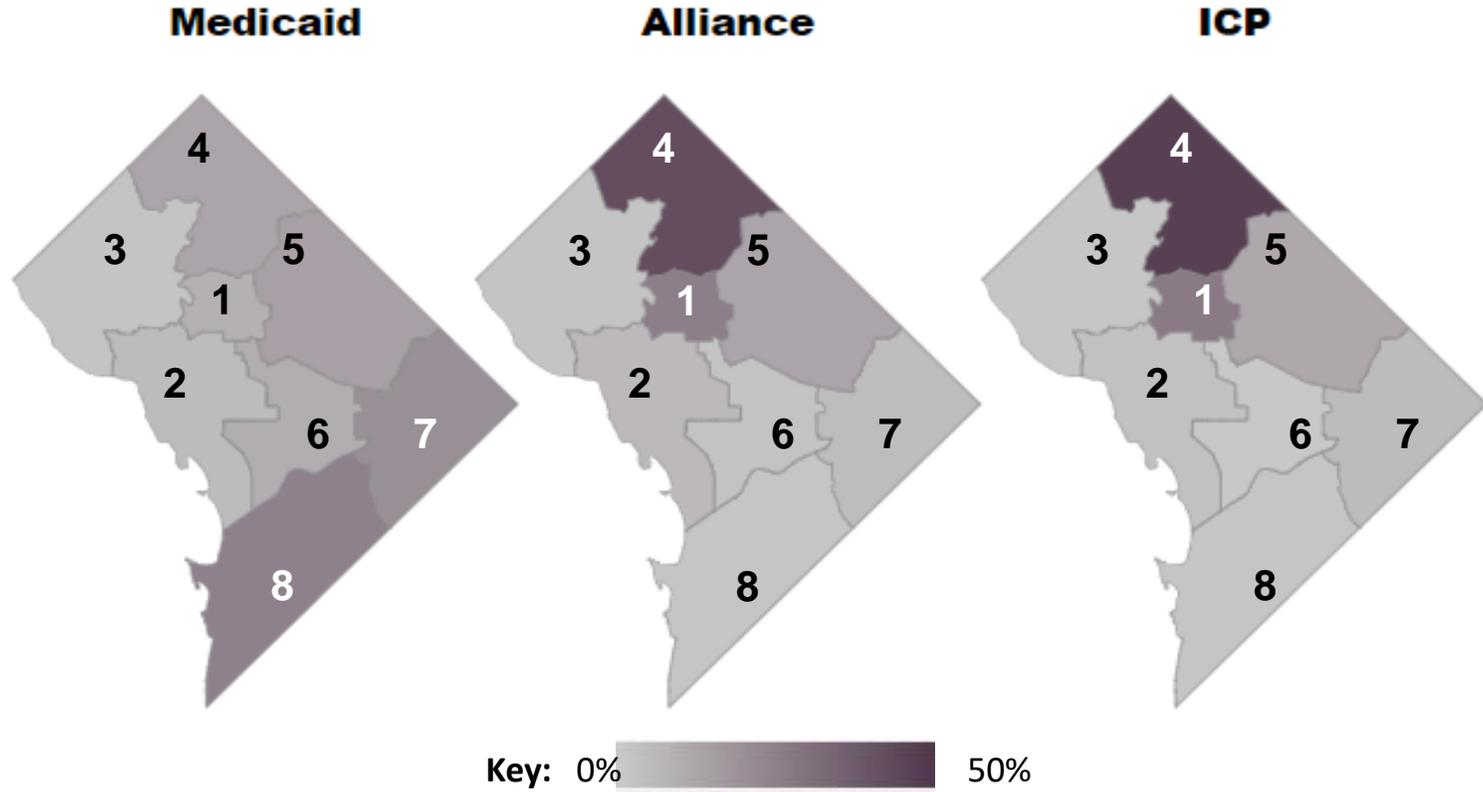


Source: District population estimate reflects July 1, 2021, from [U.S. Census Bureau](https://www.census.gov). Medicaid, Alliance, and ICP data reflects January 2022 enrollment as of 1/31/2022 from DHCF's Medicaid Management Information System.

Note: The District resident total was substantially revised downward due to the 2020 Census and may undercount certain individuals (e.g., those who are not U.S. citizens) and thus the percentage with DHCF coverage may be overstated. Sum of components may not equal total due to rounding.

Most Medicaid Beneficiaries Live in Wards 7 and 8, While Most Alliance and ICP Beneficiaries Live in Wards 1 and 4

Ward Distribution by Program Type, FY 2021

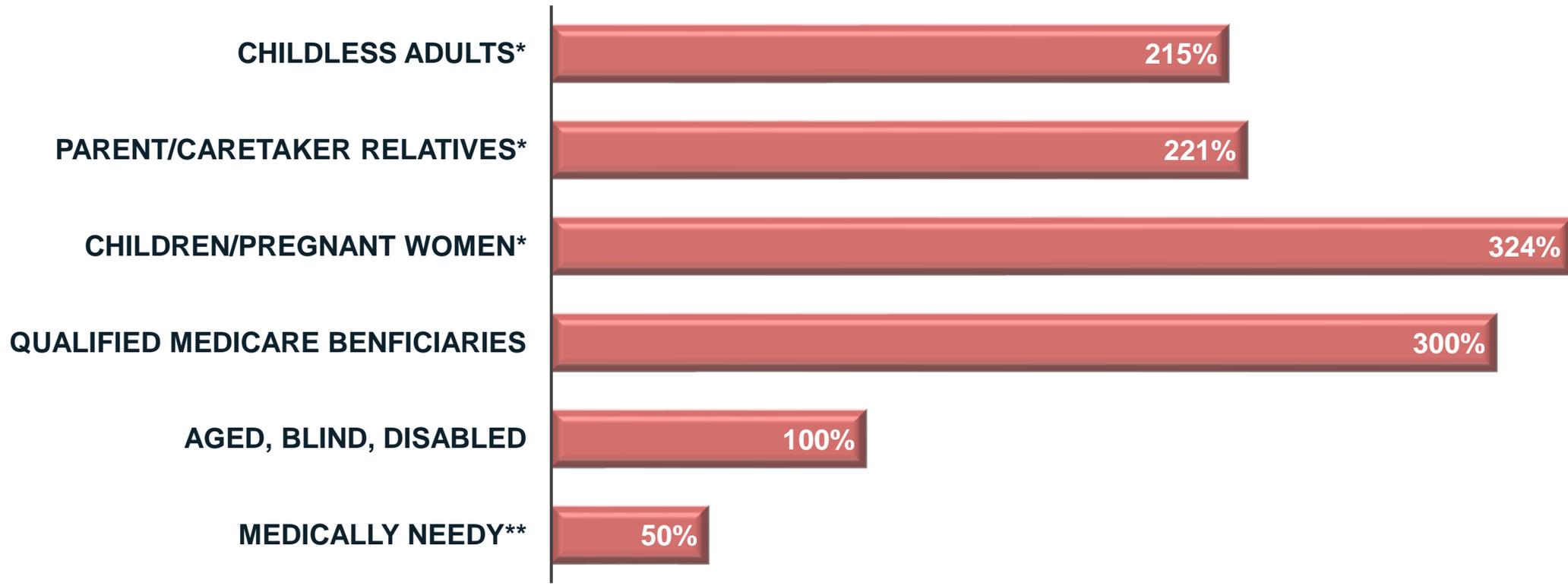


Ward	Medicaid	Alliance	ICP
1	9%	23%	25%
2	5%	6%	3%
3	2%	2%	2%
4	13%	37%	42%
5	14%	12%	11%
6	10%	2%	1%
7	20%	4%	5%
8	24%	2%	2%
Other*	4%	12%	10%

Source: DHCf Medicaid Management Information System data extracted in March 2022. **Note:** Based on average monthly enrollment. ICP = Immigrant Children's Program. Sum of components may not equal total due to rounding. *Other includes cases where a mapping is not readily available (e.g., due to a non-standard address format).

In the District, Most Low-Income Non-Elderly Adults Are Medicaid-Eligible

DC Medicaid Income Eligibility by Federal Poverty Level (FPL)



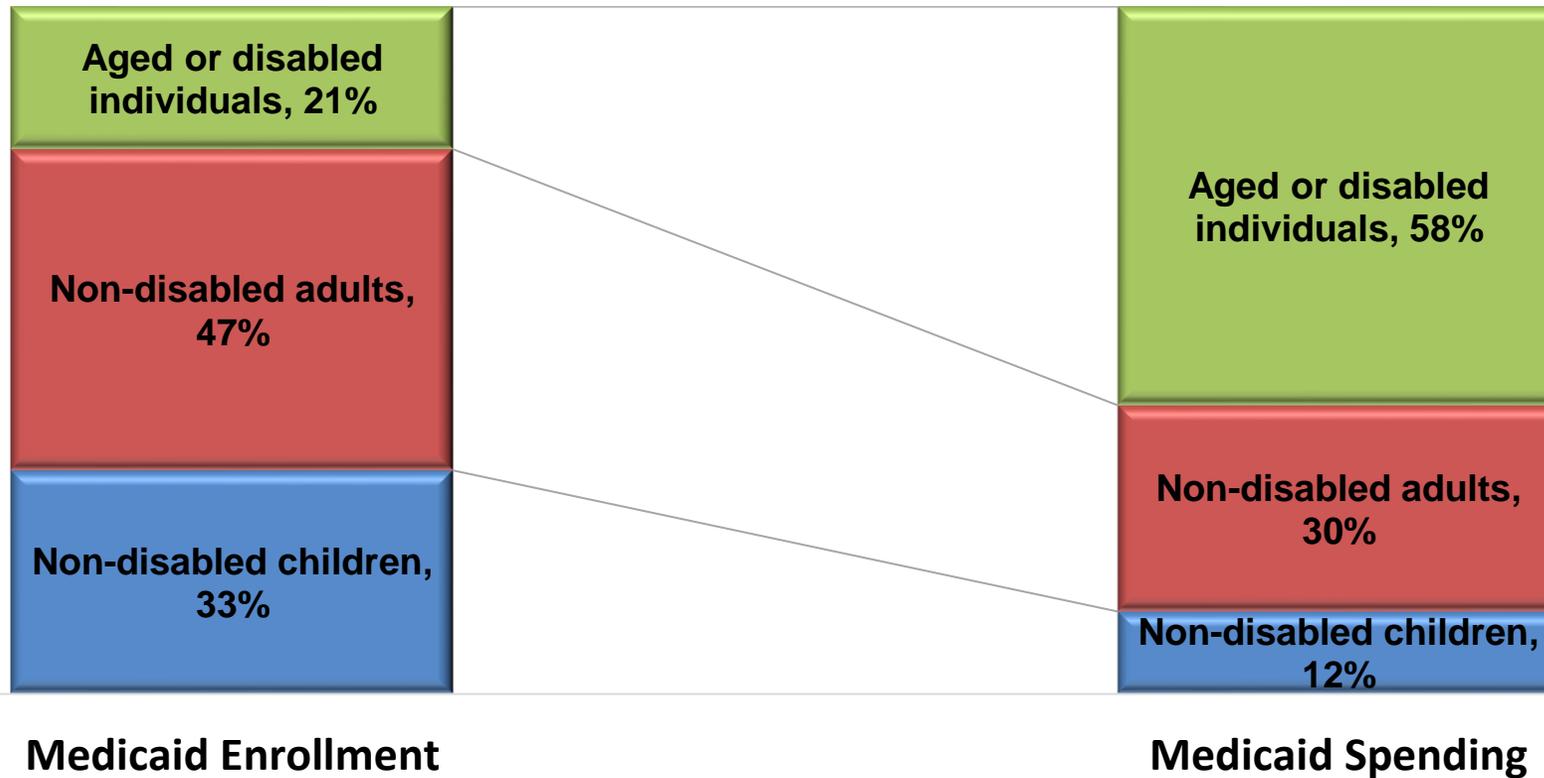
Note: Low-income is 200% FPL, which is \$27,180 for an individual or \$55,500 for a family of four in 2022.

* Includes a 5% income disregard.

** The Medically Needy Income Level (MNIL) in 2022 is 50% of the FPL for a household of 2 or more and 64% of the FPL for a household of 1.

Aged and Disabled Beneficiaries Account for About 20% of Enrollment, But Nearly 60% of Spending

Medicaid Enrollment and Spending by Eligibility Group, FY 2021

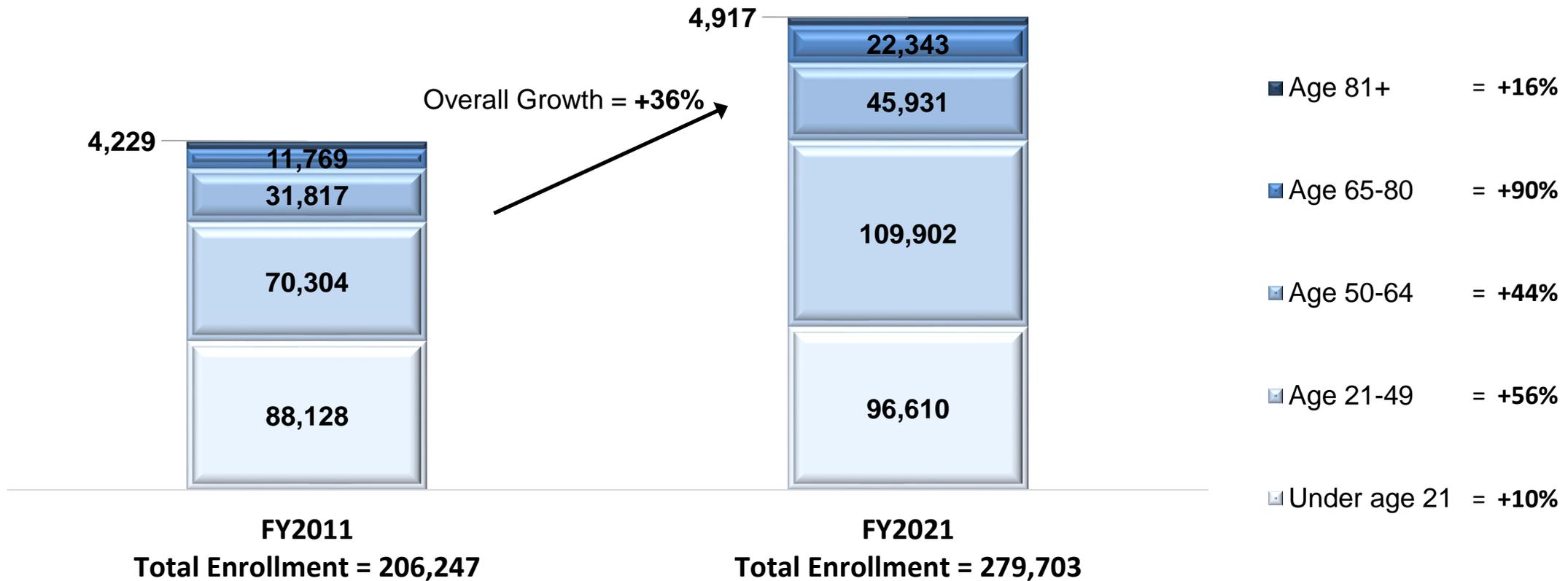


Source: DDCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility in FY 2021 and claims with dates of service in FY 2021.

Note: Reflects eligibility group at the time of payment. Disabled includes individuals eligible for long-term services and supports an institutional level of care. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Adults Account for Most Medicaid Enrollment Growth From FY 2011 to FY 2021

Medicaid Enrollment Growth by Age, FY 2011-FY 2021

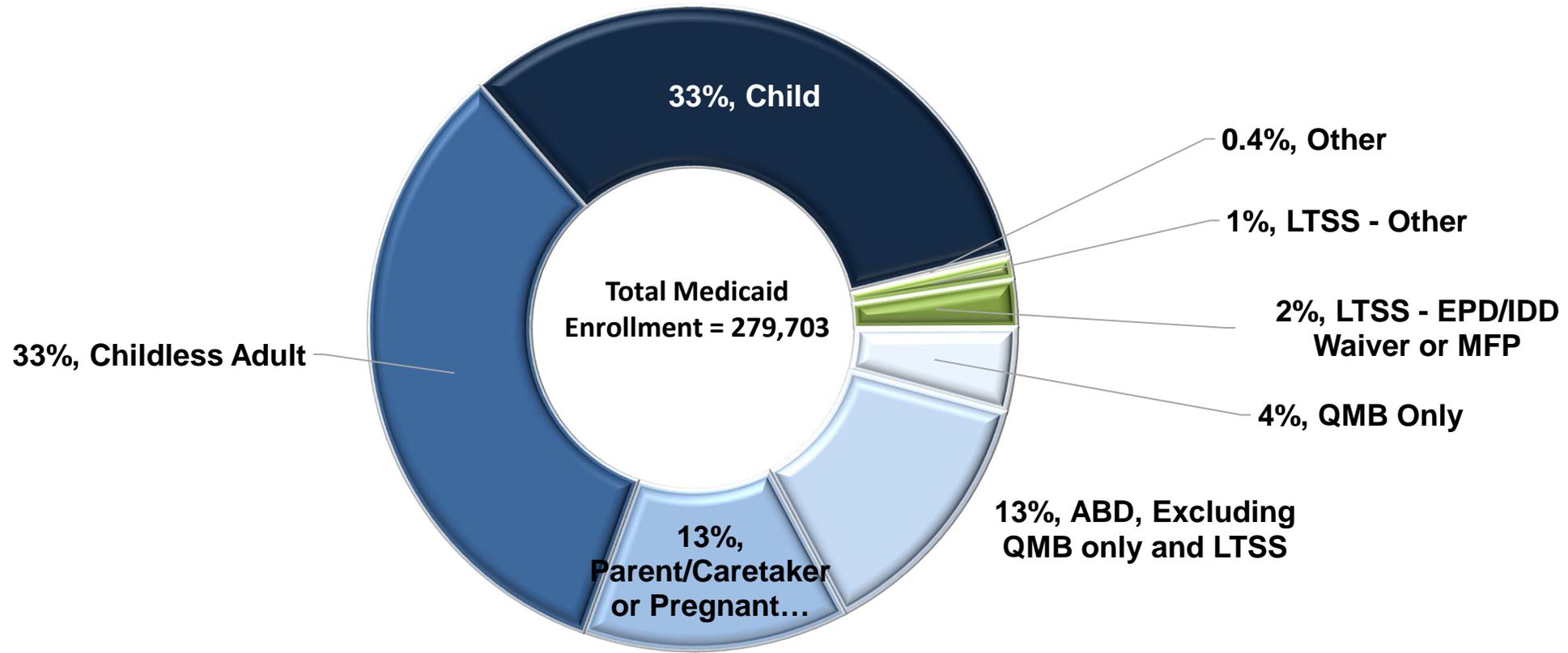


Source: DHCf Medicaid Management Information System data extracted in March 2022.

Note: Enrollment reflects average monthly.

Childless Adults and Children Each Represent About One-Third of Medicaid Enrollees

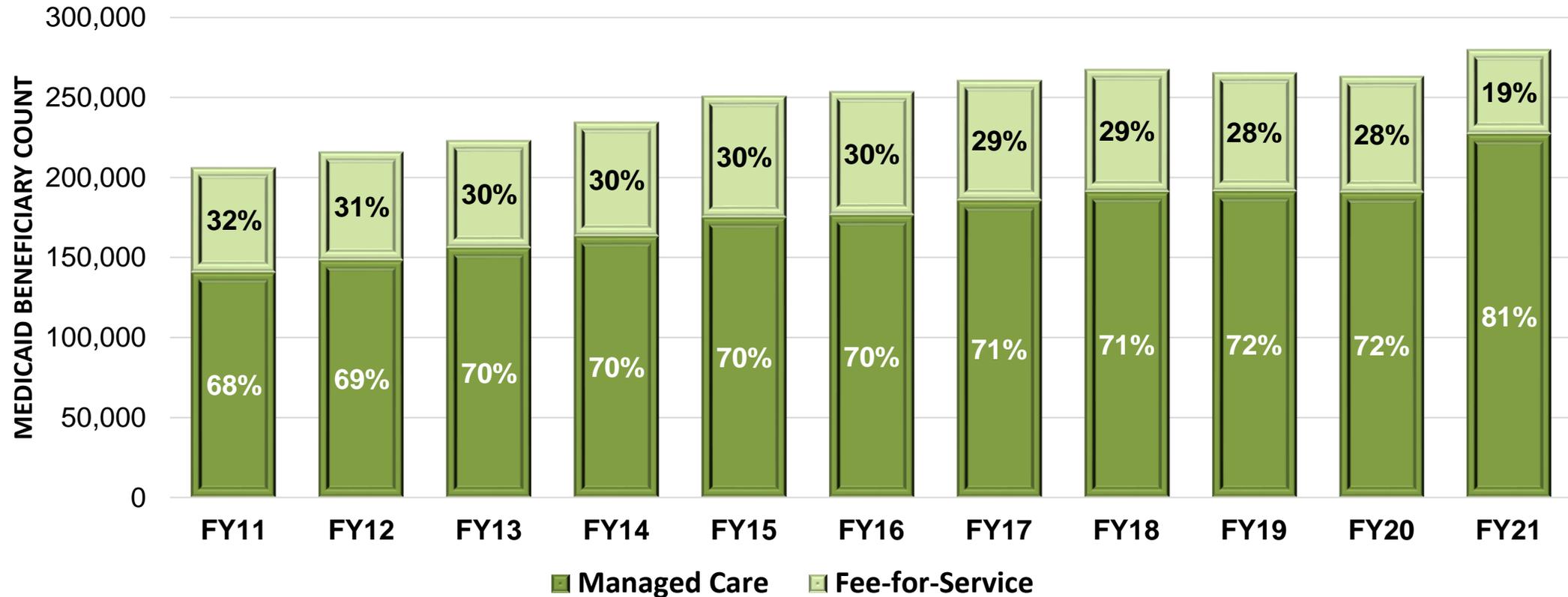
Medicaid Enrollment by Eligibility Category, FY 2021



Source: DHCF Medicaid Management Information System data extracted in March 2022.
Note: Enrollment reflects average monthly. ABD = aged, blind, or disabled; EPD = Elderly and Persons with Disability; ICF = intermediate care facility; IDD = Intellectual or Developmental Disability; LTSS = long-term services and supports; MFP = Money Follows the Person; NF = nursing facility; QMB = Qualified Medicare Beneficiary.

More Than 80% of the District's Medicaid Enrollees Are in Managed Care

Medicaid Enrollment by Service Delivery Type, FY 2011 to FY 2021

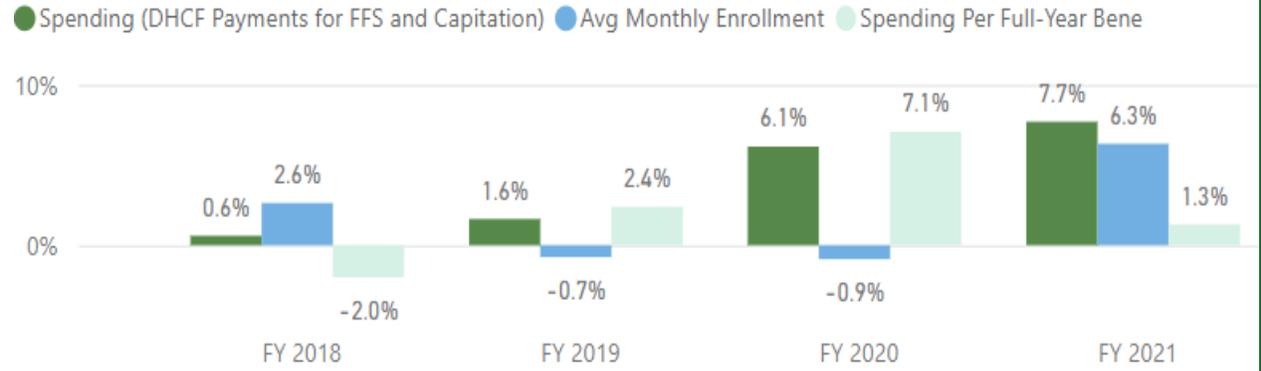


Source: DHCF Medicaid Management Information System data extracted in March 2022.

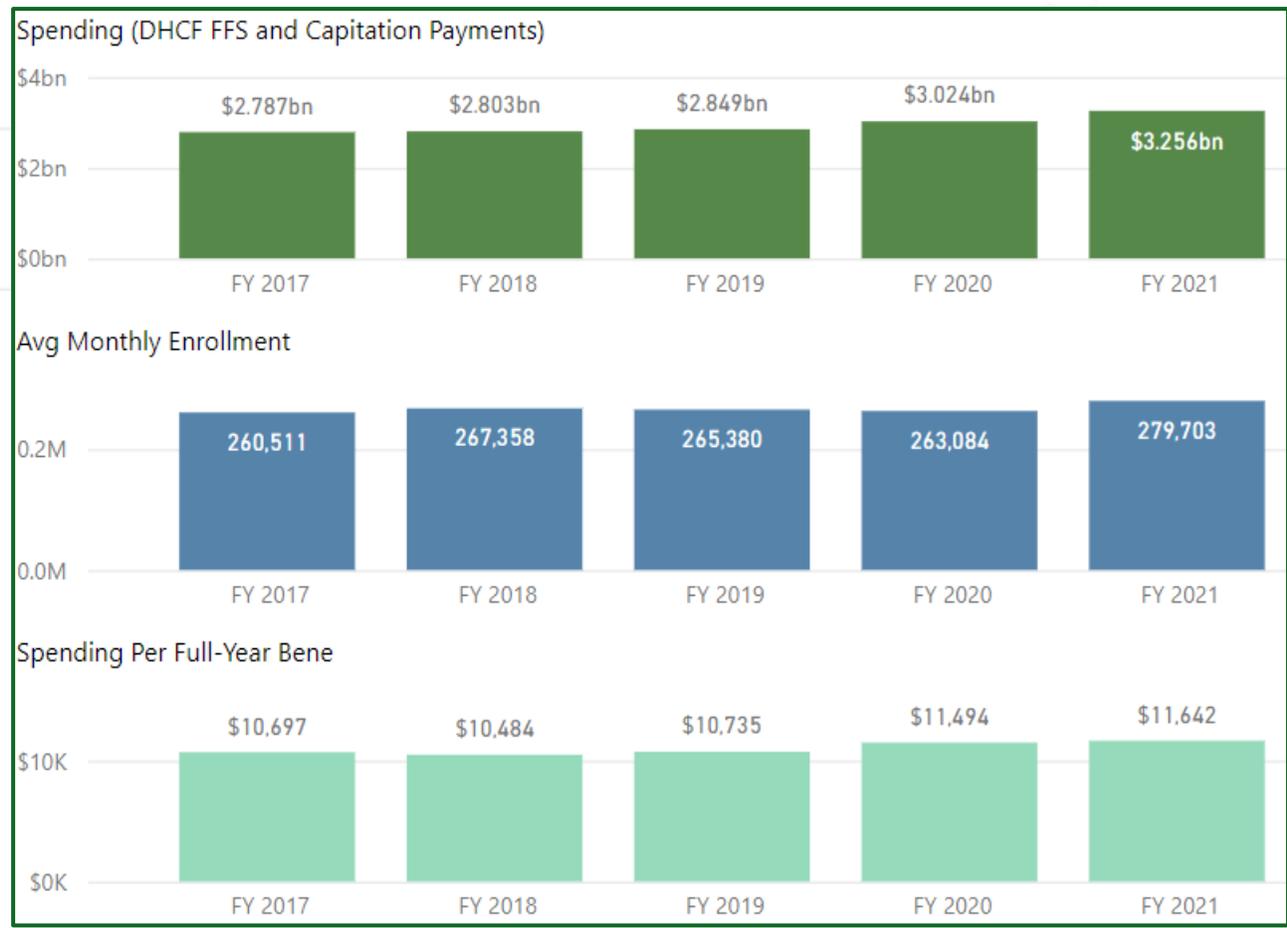
Note: Enrollment reflects average monthly.

Enrollment and Spending Per Beneficiary Contributions to Overall Medicaid Growth Have Varied Over Time

Annual Growth



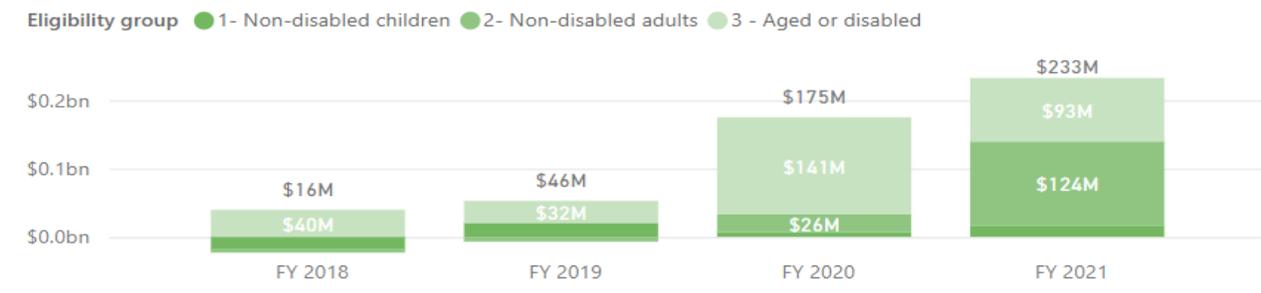
- In FY 2021, growth in **average monthly Medicaid enrollment (6.3%)** was a key contributor to growth in **overall Medicaid spending (7.7%)** while **spending per beneficiary (1.3%)** played a smaller role; enrollment was also the largest contributor in FY 2018
- In FY2020, growth in **spending per beneficiary (7.1%)** was a key factor driving **overall Medicaid spending growth (6.1%)** as there was a slight decrease in **average monthly Medicaid enrollment (-0.9%)**; spending per beneficiary was also the largest contributor in FY 2019



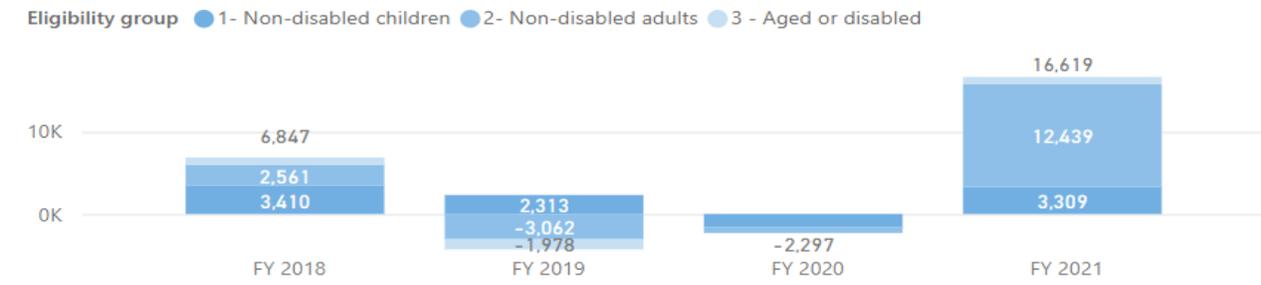
Source: DHCf Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with dates of service in FY 2021.
Note: Spending reflects DHCf payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Child, Adult, and Aged/Disabled Population Contributions to Medicaid Growth Also Vary

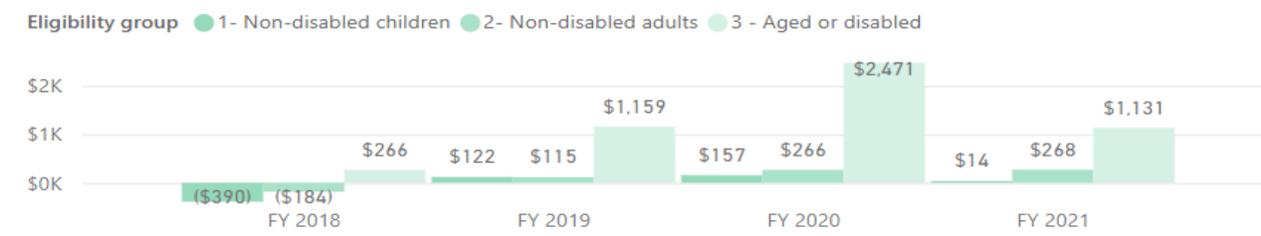
Annual Growth in Spending (DHCF FFS and Capitation Payments)



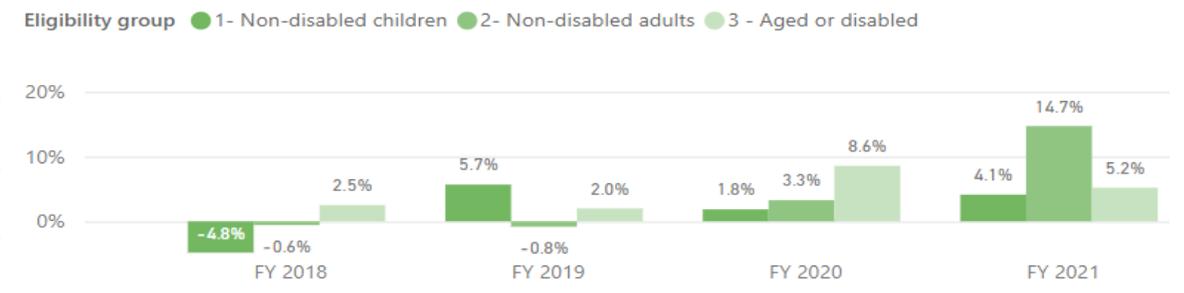
Annual Growth in Avg Monthly Enrollment



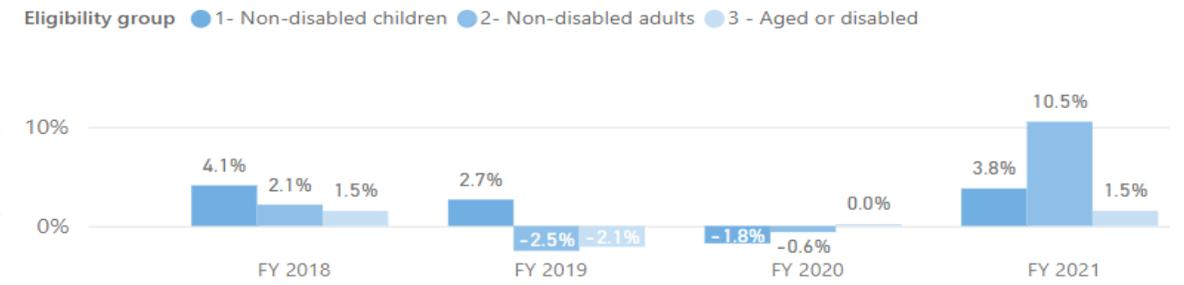
Annual Growth in Spending Per Full-Year Bene



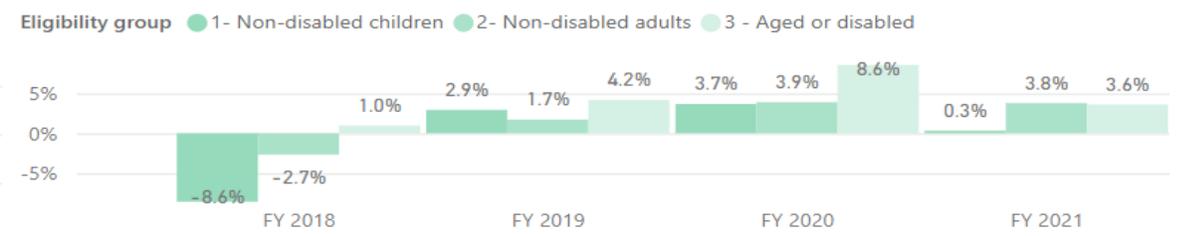
Annual Growth in Spending (DHCF FFS and Capitation Payments)



Annual Growth in Avg Monthly Enrollment



Annual Growth in Spending Per Full-Year Bene



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with dates of service in FY 2021.
Note: Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Child, Adult, and Aged/Disabled Population Contributions to Medicaid Growth Also Vary (continued)

FY 2021

Non-disabled adult enrollment and aged/disabled spending per beneficiary were key drivers of the \$233 million in overall Medicaid spending growth

- Non-disabled adults accounted for \$124 million (14.7% growth for this group) out of the \$233 million; this was mostly attributable to enrollment growth (10.5%), with spending per beneficiary growth (3.8%) playing a smaller role
- Aged and disabled beneficiaries accounted for \$93 million (5.2% growth for this group); this reflected modest enrollment growth (1.5%) as well as spending per beneficiary growth (3.6%)
- Non-disabled children accounted for the remaining \$16 million (4.1% growth for this group); this was largely due to enrollment growth (3.8%) rather than spending per beneficiary growth (0.3%)

FYs 2018-2020

Aged and disabled beneficiaries were the largest contributor to overall Medicaid spending growth, but reasons varied

- For example, growth in overall spending for this group in FYs 2019-2020 was entirely due to spending per beneficiary, as enrollment was flat or decreased
- In FY 2018, growth was attributable to an increase in both spending per beneficiary and enrollment

FY 2019

Spending on non-disabled adults fell by 0.8%, due to a decrease in enrollment

FY 2018

Spending on non-disabled children fell by 4.8%, due to a decrease in spending per beneficiary

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with dates of service in FY 2021.

Note: Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

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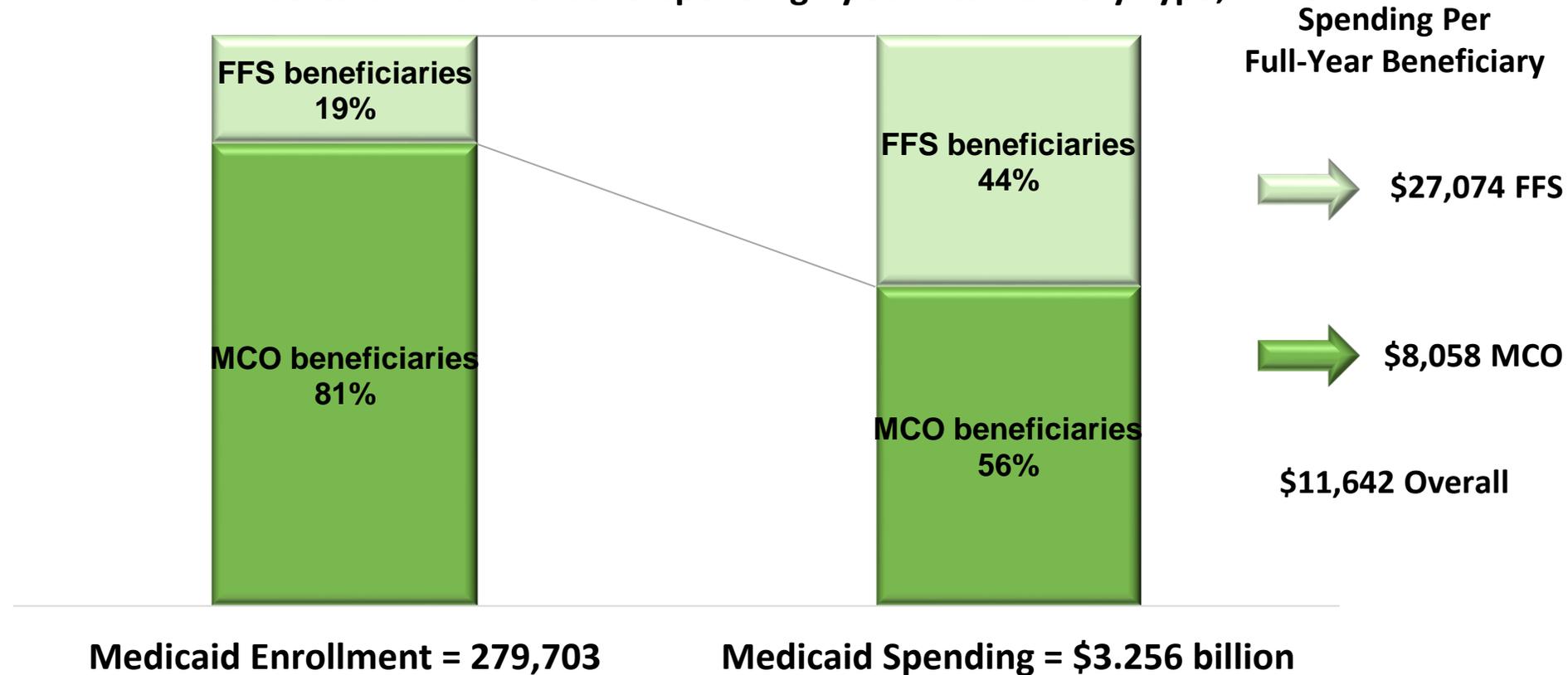
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Managed Care

Lisa Truitt

Most Beneficiaries Are in Managed Care But Spending Is Substantial for Those Remaining Fee-For-Service

Medicaid Enrollment and Spending by Service Delivery Type, FY 2021



Medicaid Enrollment = 279,703

Medicaid Spending = \$3.256 billion

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility in FY 2021 and claims with dates of service in FY 2021.

Note: Enrollment reflects average monthly and spending per full-year beneficiary reflects the average cost over 12 months. Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

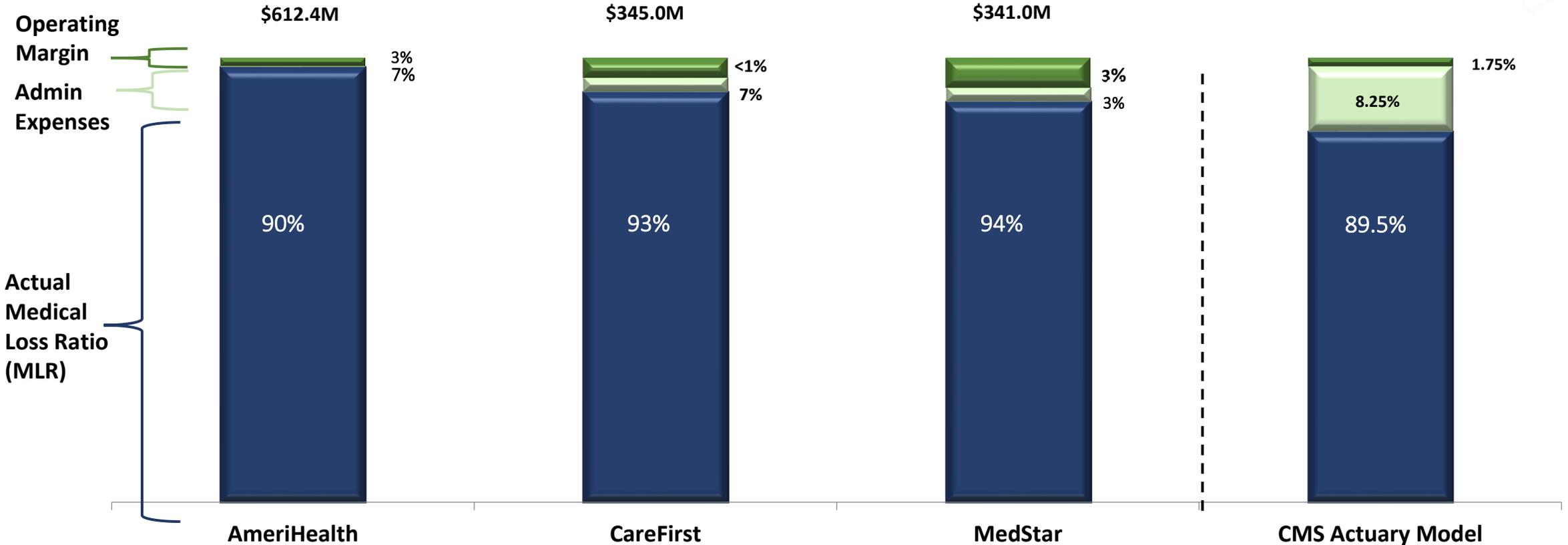
Lower Incidence of Chronic Disease in Managed Care Compared to FFS

- **FFS Medicaid-enrolled adults were most likely to have the following chronic conditions:**
 - Hypertension (48%)
 - Diabetes (27%)
 - Hyperlipidemia (27%)
 - Rheumatoid Arthritis/Osteoarthritis (19%)
 - Chronic Kidney Disease (18%)
- **FFS Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
 - Asthma (8%)
 - Depression (3%)
 - Anemia (2%)

- **MCO Medicaid-enrolled adults were most likely to have the following chronic conditions:**
 - Hypertension (19%)
 - Hyperlipidemia (11%)
 - Depression (9%)
 - Diabetes (9%)
 - Asthma (9%)
- **MCO Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
 - Asthma (10%)
 - Depression (3%)
 - Anemia (2%)

The Unquestioned Value Of Universal Contracting In The Managed Care Program

Actual MCO Revenue for January 2021 to December 2021



• Source: MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the four full-risk MCOs that operated during 2021

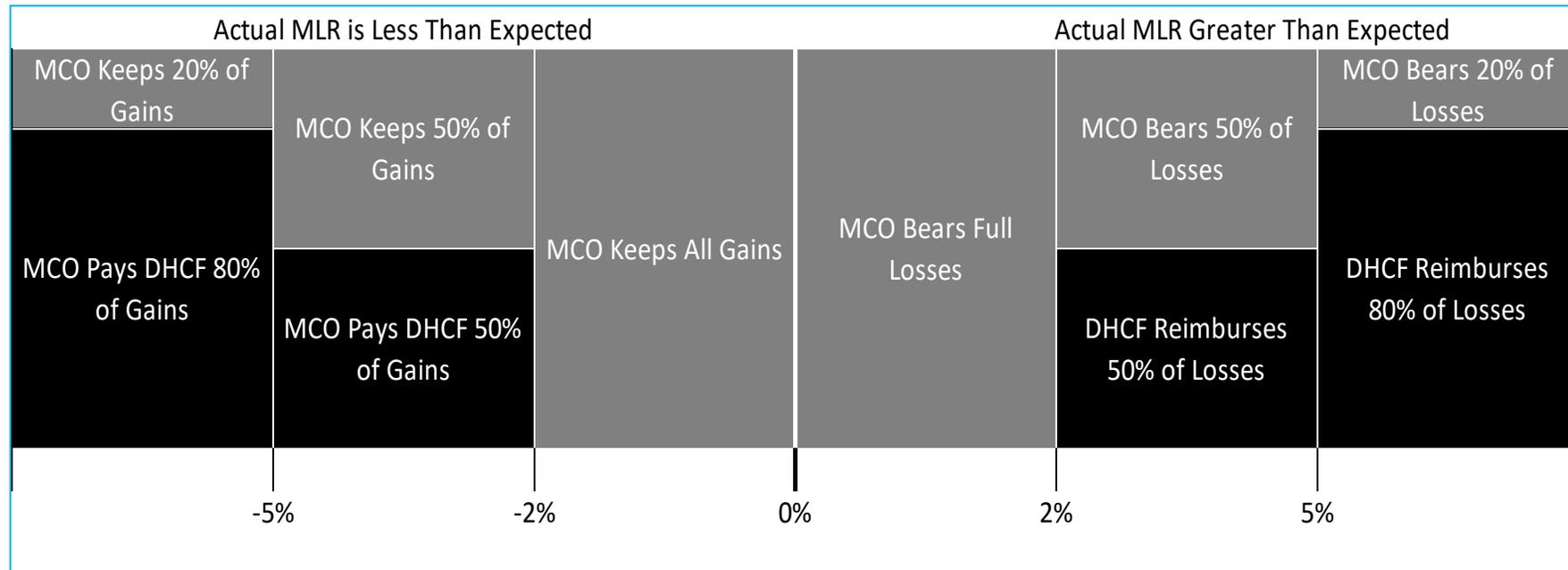
• Note: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. MLR numerator is medical expenses – i.e., total annual incurred claims (including incurred but not reported (IBNR)) and cost containment expenses as of December 31, 2021, net of reinsurance recoveries. DHCF requires through its managed care contracts that all full-risk MCOs maintain a minimum MLR of 85%. *MCO reported reserve estimates included in DISB filings impact reported medical expenses and MLR amounts, and actual claims expense may differ from estimated reserves.

Methodological Rate Shift (Risk Corridors)

DHCF implemented risk corridors for the DCHFP and Alliance programs starting in FFY 2022. Prior to FFY 2022, these programs were full risk to the MCOs. The CASSIP has had a risk corridor in place prior to FFY 2022.

- What is a risk corridor?** A risk corridor is a two-sided financial risk mitigation tool that provides protection to both the MCOs and the District by limiting the losses or gains an MCO can experience during a specified time period. The MCO retains much of the front-end risk of this arrangement, with the District sharing in an increasing share of the risk if the costs escalate.

The risk corridor for DCHFP and Alliance is designed around the Medical Loss Ratio (MLR) developed in rate setting as follows:



Several Metrics Quantitatively Assess the Efforts by MCOs to Achieve Value in Health Care

DHCF continues to monitor the Pay for Performance (P4P) indicators for each of the District's full-risk health plans but suspended the financial withhold in FY 2021 due to a new procurement of health plans.

P4P indicators include:

- Emergency room utilization for non-emergency conditions
- Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care
- Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days – hospitalization

DHCF continues to develop and implement provider-level practice transformation initiatives (i.e., Integrated Care DC, RevUp DC, and the business transformation grant) to assist in their successful transition to value-based payment models as a part of the MCO VBP contract requirements.

Medicaid MCO Results Mixed During FY 2021 due to SSI Inclusion, COVID-19

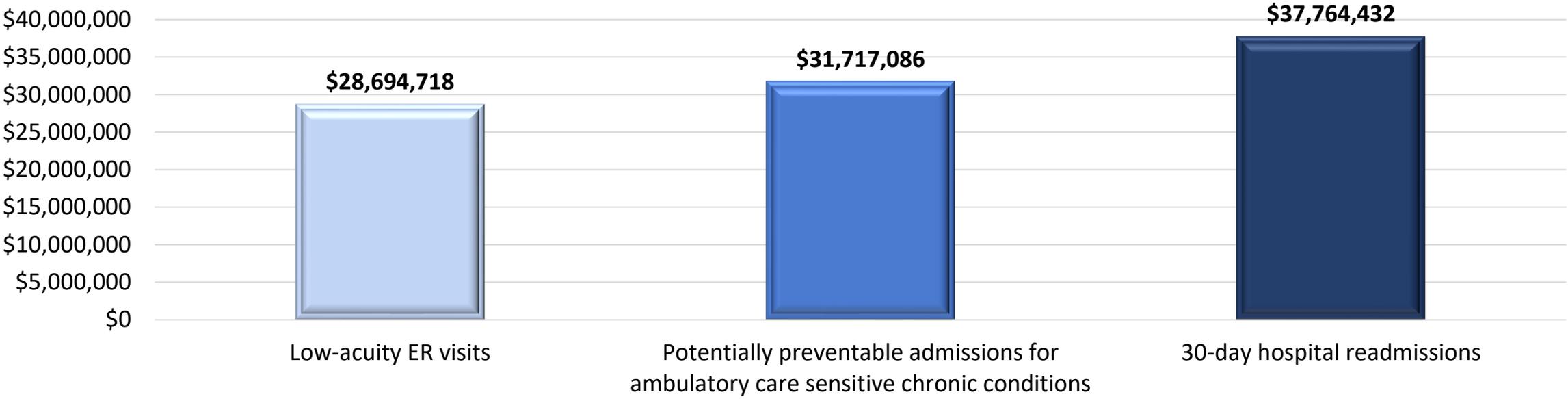
Performance Metrics			
Health Plan	Preventing Use of Emergency Room for Non-Emergencies	Preventing Hospital Readmissions Within 30 Days of Previous Admissions	Preventing Avoidable Hospital Admissions
Did the Health Plan Improve From FFY20 Results?			
AmeriHealth	Yes	No	No
CareFirst	Yes	No	No
MedStar	*	*	*

Health Plan Improvement From FFY20			
AmeriHealth	9.5%	-58.0%	-29.4%
CareFirst	6.4%	-48.9%	-48.0%
MedStar	*	*	*

- **Source:** Calculations performed by Mercer Consulting using MCO encounter data.
- **Note:** Results reflect experience from FFY21 (October 2020 to September 2021) with runout through December 2021. In FFY21 SSI Adults transitioned to the managed care program. This population has significantly higher PPA and inpatient readmission rates, which drives the rise in these metrics when comparing FFY20 to FFY21. Both FFY20 and FFY21 experience is affected by depressed medical service utilization due to the impact of COVID-19, which may influence the P4P metric results.

Over \$ Million Medicaid Costs Potentially Avoidable in FY 2021

Potentially Avoidable Hospital Costs Among Medicaid Beneficiaries, FY 2021



Number of Medicaid beneficiaries in population analyzed = 286,248

Source: DC Medicaid Management Information System (MMIS) data extracted in March 2022 for FFS claims and MCO encounters with FY 2021 dates of service.

Note: Beneficiaries identified were enrolled in Medicaid as of September 2021. There may be an undercount of service use for enrollees who are dually eligible for Medicare due to incomplete crossover claims.

Well Child Visit Rates Have Fallen During the COVID-19 Pandemic

Fiscal Year	Percentage of Children Under 21 with a Well Child Visit	Number of Children Under 21 with a Well Child Visit	Total Children Under 21
2018	63%	57,528	91,450
2019	63%	59,535	94,048
2020	50%	46,234	92,023
2021	54%	52,252	96,294

- Prior to the COVID-19 pandemic, the percentage of Medicaid children receiving a well child visit was steady or increasing
- Similar to other states, the District experienced a drop in well child visits early in calendar year 2020 that coincided with the start of the pandemic
- Well child visits rates have not yet rebounded to reach pre-pandemic levels, but the rate increased from 50% to 54% between FY 2020 and FY 2021

Source: CMS Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report. Results are preliminary for FY 2021.

Note: Reflects Medicaid beneficiaries under the age of 21 with at least 90 days of continuous coverage.

Pharmacy

Lisa Truitt

Drugs in the Pipeline and Pharmacy Payment Trends

New and evolving drug treatments

- Drugs in the pipeline that may have a fiscal impact in FY23 includes treatment for Cancer, Alzheimer’s Disease, Plaque Psoriasis, and Type 2 Diabetes.

Pharmacy Payment Trends

FFS	FY 2019	FY 2020	FY 2021
Pharmacy total	\$216,218,694	\$226,527,602	\$165,745,862

FFS Pharmacy

- Drugs that have impacted pharmacy costs are treatments for HIV/AIDS, Antipsychotics, Pulmonary Arterial Hypertension (PAH) Oral & Inhaled Agents, Opioid Dependence (Medication-Assisted Treatment) & Movement Disorders
- 27% decrease from FY20 to FY21 due to the transition from FFS to MCO of the Adults with Special Health Care Needs population, effective 10/1/2020.

MCO population	Pharmacy PMPM trend in FY 2023 rate development
Medicaid children	+3.6%
Medicaid adults	+4.0%
Alliance adults	+6.8%

MCO Pharmacy

- Pharmacy per member per month (PMPM) trend is driven by unit cost and utilization increases
- Growth is particularly high for Alliance adults

New in FY2023: Expansion of Pharmacist Responsibility in Providing Access to Care

- **Expanding Scope of Practice for Pharmacists to provide enhanced patients services**

- Wellness screenings
- Immunizations
- Smoking Cessation counseling
- Telepharmacy counseling
- Point of care testing (HIV, influenza, blood pressure, COVID, etc.)
- Providing diagnosis for acute conditions (influenza, COVID, etc.)
- Prescribing medications under Collaborative Practice Agreements (e.g., oral contraceptives, antivirals, smoking cessation, etc.)
- Medication Therapy Management

- **Provider Status Recognition Equals Provider Reimbursement**

- Pharmacists and pharmacists' patient care services are not included in key sections of the Social Security Act (SSA), which determines provider eligibility for health care programs such as Medicare Part B and Medicaid, thereby not allowing reimbursement to be paid to pharmacists for their provision of patient care
- The omission of pharmacists as listed providers limits Medicare and Medicaid beneficiaries' access to pharmacists' services in the outpatient setting.
- Pharmacists have demonstrated their value while playing a crucial role in COVID-19 pandemic response by being available and accessible as front-line health care professionals
- The District's inclusion of pharmacists as Medicaid providers will enhance the access of beneficiaries to the most accessible of health care providers

- **Continuation of COVID-19 Enhancements**

- Maintain the flexibilities and authorities extended to pharmacists by the federal government under the District's State Plan once the PHE has ended
 - Pharmacist administration of childhood vaccines to patients ages 3 and greater to increase access to care

New in FY2023: Medication Therapy Management (MTM) Services Implementation

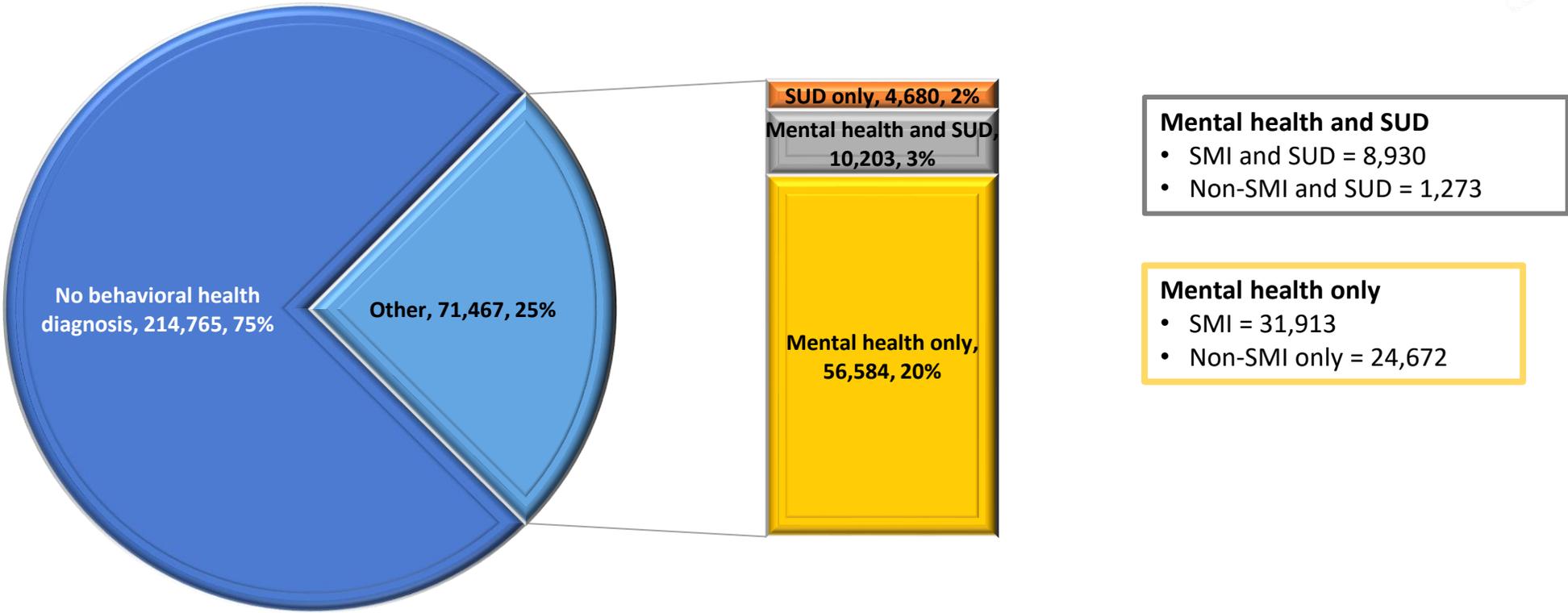
- **MTM** is service, or group of services provided by a pharmacist to a patient with the aim to optimize therapeutic outcomes for that individual patient. The services are distinct from medication dispensing & the routine patient counseling provided by a pharmacist when a patient picks up a prescription medication.
- **Services:** Medication Therapy Review (MTR), Pharmacotherapy Consults, Anticoagulation Management, Immunizations/Vaccinations, Health and Wellness Programs, & Other Clinical Services.
- **Benefits:** Offer patient-centered process of care, increase patient education of medication(s) & management of disease state(s), identify & resolve medication-related problems, reduce healthcare cost, optimize therapeutic outcomes for individual patients, provide collaboration with other healthcare providers, & support continuity of patient care.
- **Current MTM Services:** One (1) DHCF Pharmacist and Two (2) Pharmacy Benefit Manager (PBM-Magellan) Pharmacists provide telephonic MTR to select FFS Medicaid beneficiaries identified from the Pharmacy Lock-In Program, Drug Utilization Review Profiles, & PBM Case Referrals. Also, the MCO Pharmacy Directors/Pharmacists provide telephonic MTR to select MCO Medicaid & Alliance beneficiaries.
- **Future MTM Implementation:** Procure a MTM platform for documentation purposes & expand MTM services role to pharmacy providers for reimbursement, thereby impacting more FFS, MCO, and Alliance beneficiaries.

Behavioral Health

Melisa Byrd

One-Quarter of Medicaid Beneficiaries Have a Behavioral Health Diagnosis

Distribution of Behavioral Health Diagnoses Among Medicaid Beneficiaries, FY 2021



Medicaid beneficiaries = 286,232

Medicaid beneficiaries with BH diagnosis = 71,467

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022.
Note: Reflects FY 2021 diagnoses for Medicaid beneficiaries enrolled during September 2021. Behavioral health diagnoses include substance use disorders (SUD) and mental health conditions. SUD diagnoses include alcohol, opioid and other drug use and dependence. Mental health diagnoses include serious mental illnesses (SMI), such as schizophrenia and bipolar disorder, and non-SMIs, such as anxiety.

The Work on Behavioral Health Transformation Continues

Re-Procurement of the Managed Care Contracts-anticipated October 2022

- To include the majority of the BH Services not currently within the scope of Managed Care
- To include Equitable BH Benefits for Alliance Members

Comprehensive Rate Study –In progress

- Rate Enhancements
- Scheduled rate adjustments for Inflation
- New Services
- Alternative Payment Models that shift from Volume to Value

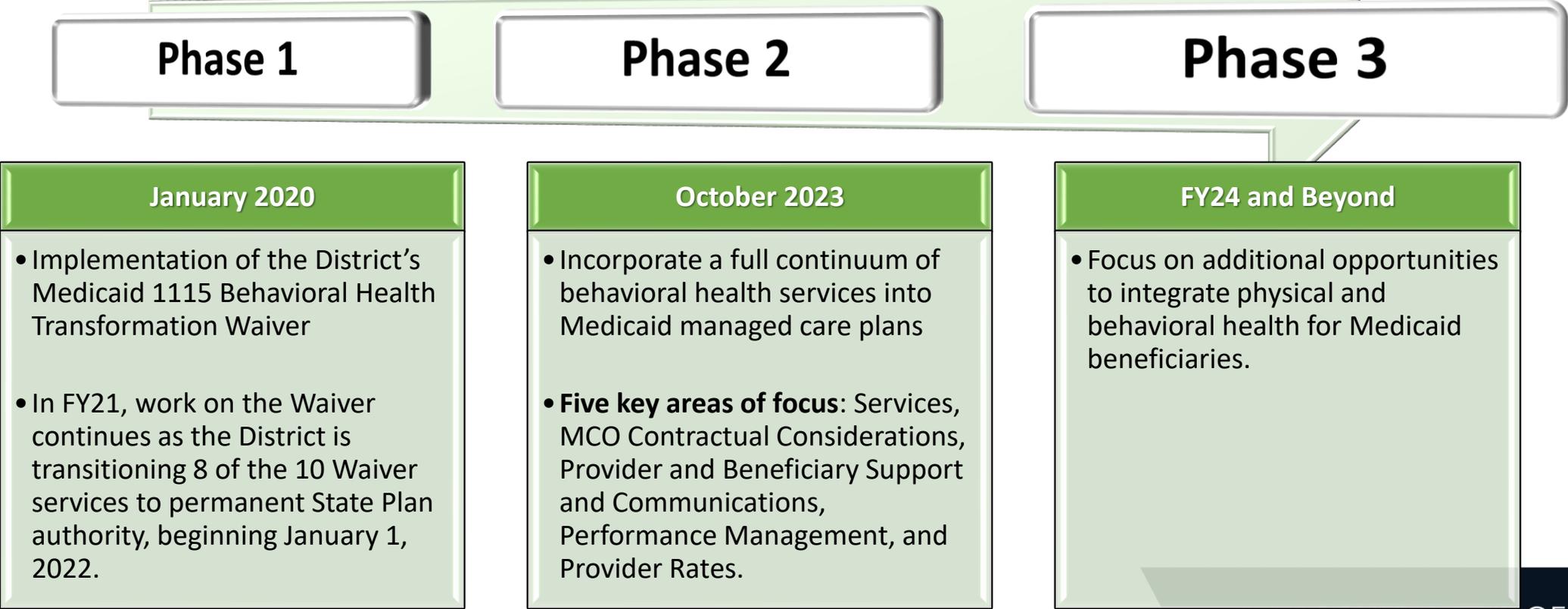
1115 BH Transformation Demonstration Waiver Service Expansion-anticipated April 2022

- Impending CMS SPA Approval to shift Waiver Services to Medicaid Authority
- Advances the District's goals to reduce Opioid Use & Deaths outlined in *Live.Long.DC*

CMS SUD Provider Capacity Grant enters its final year and will focus on sustaining infrastructure and technical assistance to achieve the District's overall objective of providing whole person care.

Planning for Behavioral Health Changes

DHCF and DBH are implementing a **three-phased approach to Medicaid behavioral health transformation** to achieve a **whole-person, population-based, integrated Medicaid behavioral health system** that is comprehensive, coordinated, high quality, culturally competent, and equitable.



Long Term Care

Katherine Rogers

Consistent With Recent Years, Home- and Community- Based Services Represent Greatest Share of LTSS Spending

Medicaid LTSS Institutional and Waiver Spending, FY 2021

Service	Total Number of Recipients*	Total Service Cost	Average Cost Per Recipient
Institutional Total*	4,162	\$400,148,841	\$96,143
Nursing Facility	3,887	\$302,524,036	\$77,830
ICF/IID	280	\$97,624,805	\$348,660
HCBS Total*	8,717	\$655,519,496	\$75,200
State Plan PCA	4,891	\$169,861,705	\$34,729
EPD Waiver	5,481	\$176,372,560	\$32,179
IDD Waiver	1,823	\$309,285,231	\$169,657
Institutional and HCBS Total*	12,925	\$1,055,668,337	\$86,262

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with FY 2021 dates of service.

Note: Numbers reflect individuals ever receiving a given service during FY 2021.

ICF = intermediate care facility; IDD = Intellectual and Developmental Disabilities; HCBS = home and community-based services; LTSS = long-term services and supports; PCA = personal care assistance; EPD = Elderly and Persons with Physical Disabilities.

* The sum of recipients across services exceeds these unduplicated totals because some individuals receive more than one of the service types shown.

The District Expanded its D-SNP Program to Improve Alignment and Service Integration for Dual Eligibles

Approximately 39,000 of DHCF's enrolled participants are dually eligible for both the Medicare program and Medicaid:

- About two-thirds are “full duals” enrolled in both Medicare and full Medicaid coverage
- About a third are “QMB only” enrolled in Medicare with some financial assistance paying Medicare cost-sharing from the Medicaid program
- Both can benefit from improved coordination across Medicare and Medicaid

The District seeks to increase Medicare-Medicaid coordination, consistent with federal standards, through its new highly integrated dual eligible special needs plan (HIDE SNP), launched February 1, 2022, in partnership with UnitedHealthcare. The program:

- Offers enhanced care management for many who otherwise lack care management
- Improves integration of benefits and reduce duplication of services between payers
- Simplifies and streamlines navigation of services for beneficiaries and their families and caregivers

The District Expanded its D-SNP Program to Improve Alignment and Service Integration for Dual Eligibles

The program covers a variety of District residents:

- ❑ About 12 percent are EPD HCBS waiver participants, accessing all of their Medicare and Medicaid benefits through one single program with an integrated, comprehensive care management approach that adheres to the standards set forth in our EPD Waiver
- ❑ More than 40 percent are “QMB only”: enrolled in Medicare with some financial assistance paying Medicare cost-sharing from the Medicaid program. These individuals have access to Medicare coverage, supplemental benefits and cost-sharing
- ❑ The balance are eligible for full Medicaid and Medicare coverage and accessing care management tailored to their health care needs and risks

The program is voluntary; beneficiaries may opt in and out according to their preference.

DHCF Continues Its Efforts to Establish the Program of All-Inclusive Care for the Elderly (PACE)

PACE is a nationally recognized model of care integrating Medicare and Medicaid benefits for some of the District's highest-need beneficiaries: individuals 55+ meeting nursing facility level of care residing in ZIP codes east of the river.

DHCF has made significant strides toward successful implementation of PACE in the District this year, including ongoing partnership with the selected PACE Organization (PACE4DC), submission of its application to CMS for review and approval, and additional policy and program development.

PACE Timeline

January 2021

Initial selection of a PACE provider through a competitive procurement

December 2021

Submission of PACE provider's CMS application

Fall/Winter 2022

Launch enrollment and begin oversight of the program

Summer 2021

Initiation of community and stakeholder engagement efforts

Spring/Summer 2022

Site development and provider readiness activities

The EPD Waiver Was Renewed for Another Five Years with Key Program Changes

Effective February 2022, CMS approved a five-year renewal of DHCF’s 1915(c) waiver program for the Elderly and Persons with Physical Disabilities. Programmatic changes included:

- Integration of Medicare and Medicaid for waiver enrollees through the HIDE SNP program
- Increased efficiency and automation in the provider enrollment process
- Administrative process improvements for the *Services My Way* participant-directed program within the waiver

This renewal also amended a change made in 2020 “delinking” waiver and state plan benefits, which means waiver enrollees will not be limited to a maximum of 16 hours of PCA services per day.

- This 2020 change was not effectuated during the PHE
- As a result of the change in the renewal, the 16-hour cap will also not go into effect after the PHE concludes

The renewal allows DHCF to continue the key community-based services that allow enrollees to age in place in the District, including among others:

- Assisted living facility services
- Personal care aide services
- Participant-directed services

Presentation Overview

- ~~Overview Of District's Budget For FY2023~~
- ~~Overview of Deputy Mayor, Human Support Services Cluster Priorities~~
- ~~Cedar Hill Regional Medical Center Progress~~
- ~~DHCF Program Overview~~
- ~~DHCF Budget Development and Rates~~
- ~~Building Infrastructure to Support Program Value & Accountability~~
 - ~~DC Access System Eligibility System~~
 - ~~Health Information Exchange~~

- Medicaid Program Overview**
 - Eligibility
 - Enrollment
 - Utilization and Spending Trends
- Medicaid Program Trends**
 - Medicaid Managed Care
 - Pharmacy
 - Behavioral Health
 - Long-Term Care
- Alliance**
- Questions**

Updates To Alliance Coverage Eliminate Barriers to Coverage and Expand Access to Care

- Alliance beneficiaries now have access to non-emergency transportation to maternal related medical appointments through their health care coverage
- Alliance beneficiaries no longer must recertify face to face and can utilize the various modes of application (mobile, on-line, fax and in person)
- Alliance beneficiaries are only required to recertify once a year

DC Healthcare Alliance and the Immigrant Children’s Program Use Local Funds to Cover Low-Income Noncitizens Who Are Ineligible for Medicaid

DC Alliance and ICP Income Eligibility by Federal Poverty Level (FPL)



Key facts about Alliance/ICP:

- Alliance beneficiaries accounted for 7% of DHCF program enrollment in FY 2021; ICP beneficiaries accounted for about 1%
- Most Alliance and ICP beneficiaries live in Wards 1 and 4, compared to Wards 7 and 8 for Medicaid beneficiaries
- Noncitizens are more likely to be uninsured than citizens; however, the District’s 2019 uninsured rate for noncitizens (12.7%) was substantially less than the national rate (32.1%)

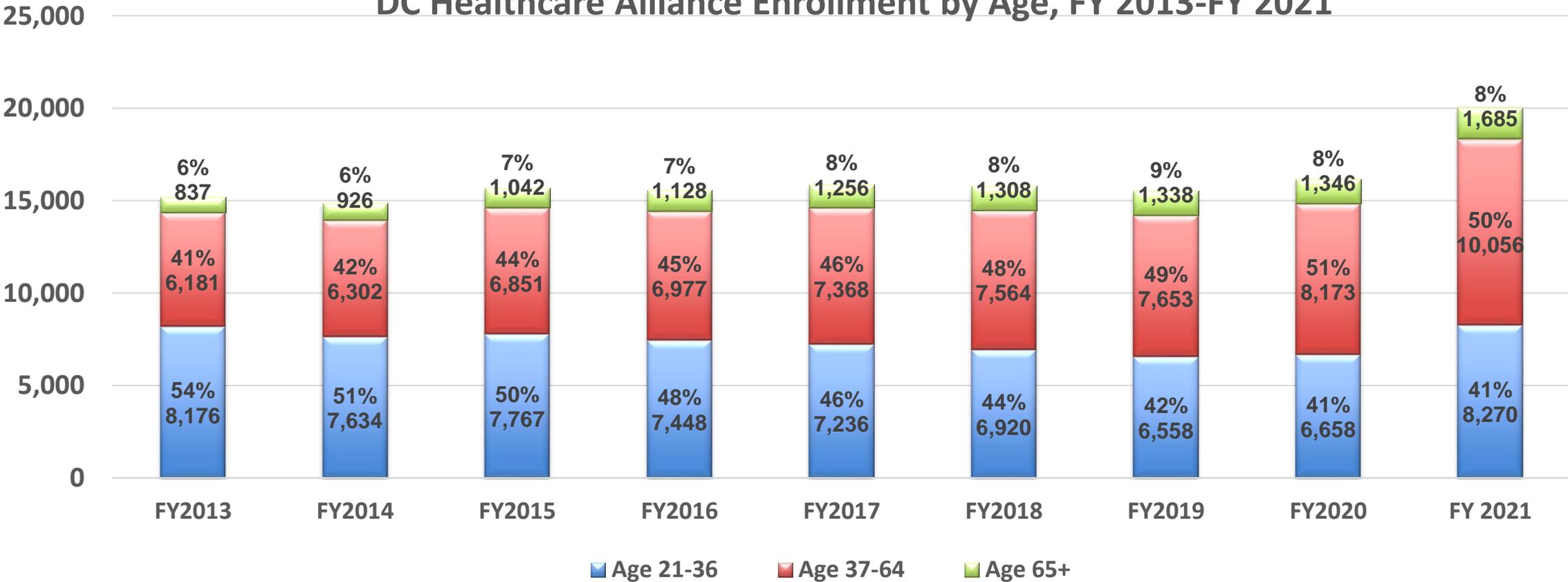
Note: Low-income is 200% FPL, which is \$27,180 for an individual or \$55,500 for a family of four in 2022.

* DHCF is in the process of rulemaking to align Alliance and ICP income thresholds and methodologies with Medicaid income levels shown here. Current thresholds for Alliance and ICP are at 200% FPL.

** Data extracted from U.S. Census Bureau, 2019 American Community Survey 1-year estimates. Rates reflect the civilian noninstitutionalized population.

Overall Alliance Enrollment Has Increased Substantially During the PHE; Alliance Population Age 37+ Has Grown While Younger Population Has Fallen

DC Healthcare Alliance Enrollment by Age, FY 2013-FY 2021



Source: DHCF Medicaid Management Information System data extracted in March 2022.

Note: Data reflects average monthly enrollment. Age 37 corresponds with a cutoff used to determine managed care rates.

Prior to Continuous Coverage Provided During Public Health Emergency, Nearly 4 in 10 Alliance Beneficiaries Losing Coverage Re-Enrolled Within a Year

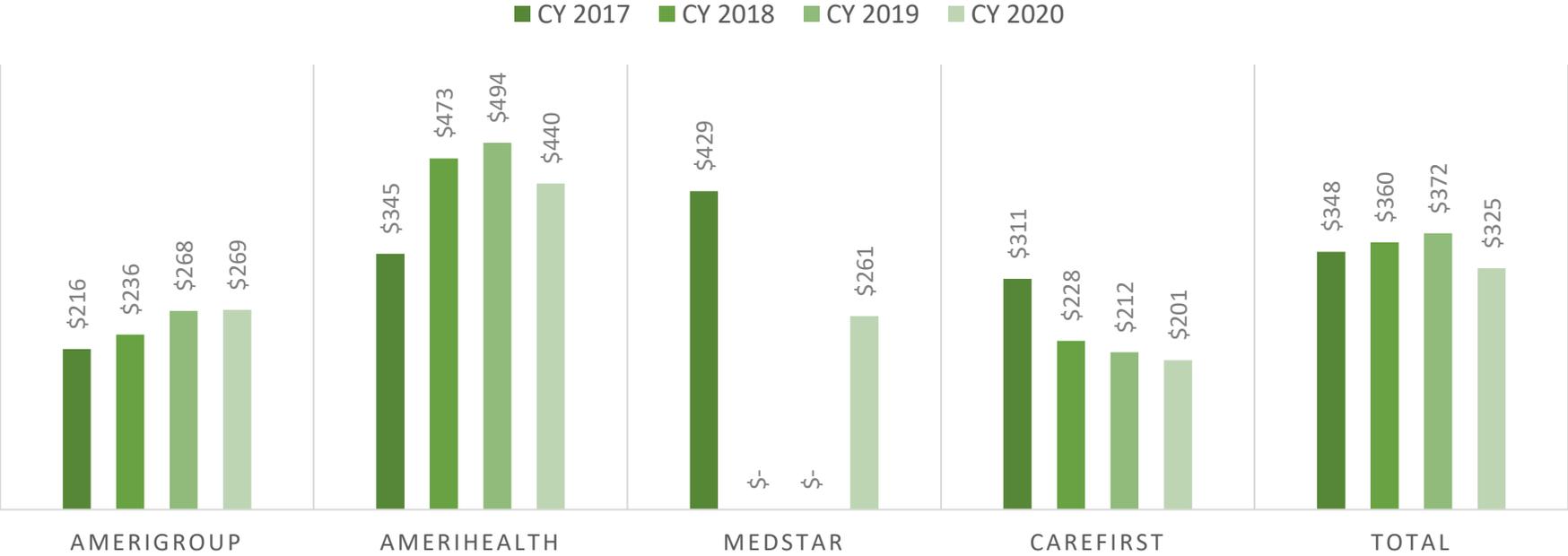
Fiscal Year	Total Alliance Beneficiaries Ever Enrolled	Total Terminated	Total Terminated and Re-enrolled in Alliance Within 1 Year	Total Terminated and Re-enrolled in Medicaid Within 1 Year	Net Terminated and Re-Enrolled in Medicaid or Alliance Within 1 Year (% of Total Terminated)
2018	21,469	7,759	3,012	148	3,160 (41%)
2019	21,179	7,312	2,888	136	3,024 (41%)
2020	20,368	3,346	934	60	994 (30%)
2021	22,299	456	18	1	19 (4%)

Source: DHCF Medicaid Management Information System data extracted in January 2022.

Note: Beneficiaries who disenrolled from the Alliance program but immediately enrolled in the Medicaid program are not included in the count of disenrolled beneficiaries. The number of Alliance enrollees who had their coverage terminated in FY 2020 and FY 2021 was significantly lower compared to prior years because coverage was automatically extended to enrollees during the public health emergency.

Alliance Cost Per Beneficiary Grew Modestly from CY 2017 – CY 2019 with Decreases in CY 2020 Due to COVID-19 Pandemic

ALLIANCE ADULT MEDICAL EXPENSES PER MEMBER PER MONTH (PMPM)



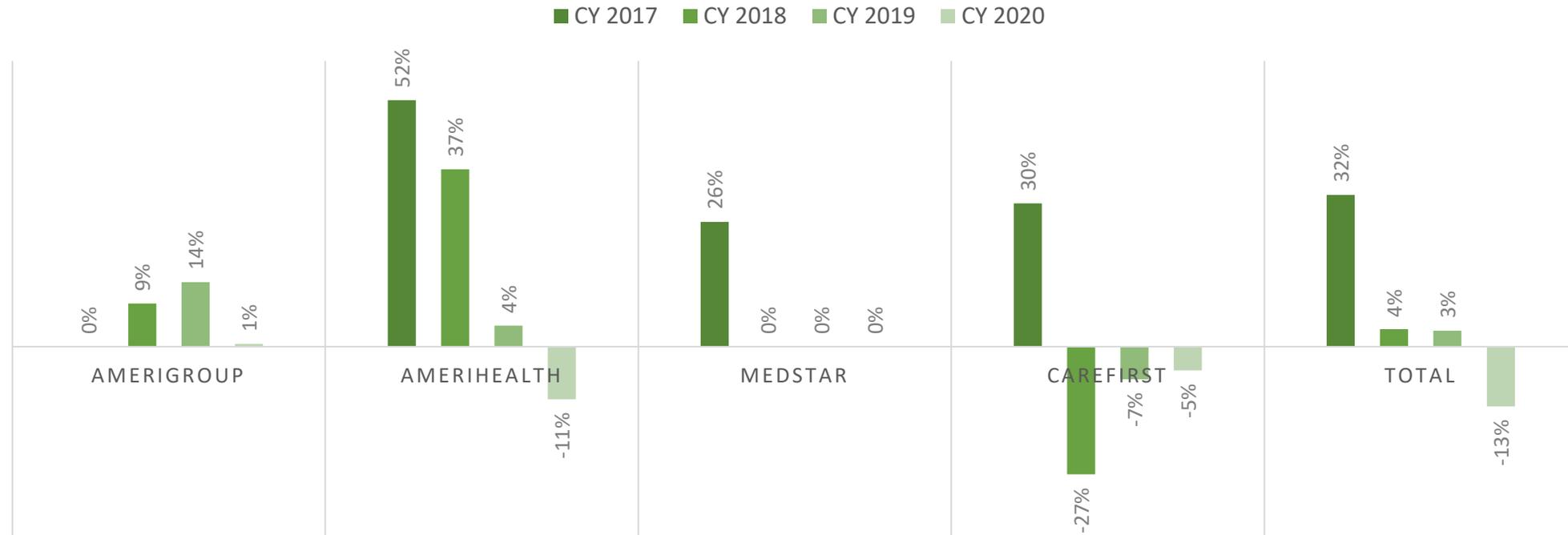
Source: Mercer Consulting

Notes:

- All results are based on financial medical claim data provided by the MCOs. CY 2017 incurred claims paid as of January 31, 2018, for MedStar and as of January 31, 2019, for Amerigroup, AmeriHealth, and Trusted. CY 2018 incurred claims paid as of January 31, 2020. CY 2019 and CY 2020 incurred claims paid as of January 31, 2021. MedStar was in contract until September 30, 2017, and exited the program from October 1, 2017, through September 30, 2020. CY 2017 expenses are based on nine months of experience, and CY 2020 are based on three months. Amerigroup was in contract from October 1, 2017, through September 30, 2020. CY 2017 results are based on three months of experience, and CY 2020 are based on nine months.

Alliance Cost Per Beneficiary Grew Modestly from CY 2017 – CY 2019 with Decreases in CY 2020 Due to COVID-19 Pandemic

ALLIANCE ADULT MEDICAL EXPENSES PMPM PERCENTAGE GROWTH OVER PRIOR YEAR



Source: Mercer Consulting

Notes:

- All results are based on financial medical claim data provided by the MCOs. CY 2017 incurred claims paid as of January 31, 2018, for MedStar and as of January 31, 2019, for Amerigroup, AmeriHealth, and Trusted. CY 2018 incurred claims paid as of January 31, 2020. CY 2019 and CY 2020 incurred claims paid as of January 31, 2021. MedStar was in contract until September 30, 2017, and exited the program from October 1, 2017, through September 30, 2020. CY 2017 expenses are based on nine months of experience, and CY 2020 are based on three months. Amerigroup was in contract from October 1, 2017, through September 30, 2020. CY 2017 results are based on three months of experience, and CY 2020 are based on nine months.



Q&A



Questions on Program Overview and Trends



UNWINDING THE PUBLIC HEALTH EMERGENCY



Presentation Overview



- **Background on Medicaid Policy During Federal PHE**
- **Eligibility Changes and Operations Related to the PHE**
- **Long Term Care Changes Related to the PHE**



COVID-19 Federal Public Health Emergency



- HHS Secretary declared public health emergency (PHE) on January 31, 2020 as a result of the COVID-19 pandemic;
- The PHE has been renewed on an ongoing basis; each renewal is effective for up to an additional ninety (90) days
- The PHE was recently renewed for an additional ninety (90) days effective April 16, 2022
- Without additional action by HSS Secretary, COVID-19 PHE currently set to expire July 15, 2022
- Biden Administration has stated that it will give states a sixty (60) day notice before the PHE expires
- If the PHE will expire on July 15, the District would expect notice from Biden Admin by May 16, 2022



Medicaid Policy Flexibilities During the PHE



- ▶ In helping states respond to the PHE, CMS identified authorities available for states to effectuate programmatic, reimbursement, and policy changes in response to COVID-19:
 - Emergency Medicaid state plan amendments (E-SPA), Section 1915(c) Waiver Appendix K, and Section 1135 Waivers
- ▶ Section 1135 Waivers permit DHCF to request authority from CMS to waive or modify federal Medicaid requirements to mitigate the consequences of the COVID-19 pandemic
 - ☞ Terminate at the end of the federal PHE; CMS is ending certain blanket waivers in the next two months (e.g. **Provision of Services in Alternative Settings** will conclude on June 6, 2022)
- ▶ E-SPAs permit the District to make changes to the amount, duration, and scope of benefits covered under the Medicaid State Plan (e.g. Establish PMPQ payment for *My Health GPS*)
 - Terminate at the end of the federal PHE unless extended by the District
- ▶ Appendix K permits District to make changes to the amount, duration, and scope of benefits covered under the District's 1915(c) Home and Community-Based Waiver programs
 - Flexibilities can be in place up to six (6) months following the conclusion of the federal PHE; or an earlier date determined by the State



Extending Emergency State Plan Provisions



- ▶ On February 15, 2022 CMS issued additional guidance to States on steps that should be taken ahead of the conclusion of the PHE
- ▶ Guidance included what steps States should take with respect to E-SPA provisions. States have three options with regard to approved E-SPA provisions:
 - **Let it Expire** – allow the provision to expire at the end of the PHE; with advance notice to stakeholders and impacted beneficiaries
 - **Temporarily Extend** – extend the provision after the PHE expires through a streamlined SPA approval process; standard public notice process required (e.g. advance notice to public of proposed changes)
 - **Continue Indefinitely** - continue the change through a traditional amendment to the state plan
- ▶ CMS is directing states to establish new sections of the State Plan to facilitate temporary extensions:
 - First Section: For extension of E-SPA without modification
 - Second Section: For extension of E-SPA provisions with modification
- ▶ Temporary extensions can be made for up to one (1) year following conclusion of the PHE
 - CMS has stated that ARPA 9817 provisions may be extended temporarily through March 2024



Policy Planning Before Conclusion of the PHE



- ▶ District is working internally, across agencies, in anticipation of conclusion of the PHE
- ▶ When the District receives sixty (60) day notice from the Biden Administration:
 - Stakeholders should expect notice published to the agency Website (or *DC Register*) of E-SPA; Appendix K; and 1135 Waiver on policy flexibilities that will be concluding (along with a summary of its impact on the Medicaid program);
 - Additionally, stakeholders should expect public notice of any E-SPA provisions that will be extended (temporarily or indefinitely).
- ▶ The goal is to publish corresponding policy notices thirty (30) days prior to the conclusion of the PHE (mostly to align with District local notice requirements)
- ▶ In accordance [SHO-Letter #20-04](#), if an individual beneficiary's eligibility for specific services/program is impacted by a policy change brought on by the conclusion of the PHE, that beneficiary will receive an individualized notice, delivered timely, ahead of any adverse action taken by the District.



Policy Planning Before Conclusion of the PHE (*cont.*)



▶ **Examples of Temporary E-SPA Extensions under consideration**

- Any ARPA 9817 funded initiatives approved under E-SPA authority will likely be extended through March 31, 2024
- Some reimbursement increases may be temporarily extended (where funding permits)

▶ **Examples of Indefinite E-SPA Extensions under consideration**

- Changes adopted to My Health GPS (e.g. establishment of PMPQ reimbursement) will likely be extended indefinitely
- Adjustments to prescription day supply limits to allow and reimburse for dispensing of a 90-day supply of maintenance medications will likely be extended indefinitely
- The ICF/IID DSP Supplemental Payment will likely be extended indefinitely

▶ **Examples of Policy Provisions potentially concluding with PHE**

- FQHC APM-PMPM reimbursement changes will likely conclude at the end of the PHE
- 1915(i) and 1915(c) Adult Day Health Program reimbursement for telehealth service will likely conclude at the end of the PHE



Presentation Overview



- **Background on Medicaid Policy During Federal PHE**
- **Eligibility Changes and Operations Related to the PHE**
- **Long Term Care Changes Related to the PHE**



Significant Medicaid and Alliance Enrollment and Eligibility Changes Are In Effect to Make Care Accessible During the PHE



- Changes were necessary to ensure continuity of care and access to coverage during the first pandemic in over 100 years
- Federal government requires continuous eligibility during the PHE – meaning states cannot disenroll an individual
 - There are a few exceptions, e.g. a residents requests disenrollment
- States are incented to maintain continuous eligibility by an enhanced FMAP (eFMAP) option
 - 6.2% eFMAP available to states;
 - eFMAP is available until the last day of the last quarter the PHE is in effect (e.g. current PHE ends April 16, 2022 and the eFMAP is available until June 30, 2022)



Significant Medicaid and Alliance Enrollment and Eligibility Changes Are In Effect to Make Care Accessible During the PHE



	Medicaid	Alliance	ICP
Current Beneficiaries	<ul style="list-style-type: none"> • Eligibility automatically extended • Requirement to report changes is waived 	<ul style="list-style-type: none"> • Eligibility automatically extended • Requirement to report changes is waived • No face-to-face interview 	<ul style="list-style-type: none"> • Eligibility automatically extended • Requirement to report changes is waived
New Enrollees	<ul style="list-style-type: none"> • Allowing self-attestation of verification requirements except: <ul style="list-style-type: none"> • U.S. citizenship and eligible immigration status for all; • Level of care requirements for long term care and Katie Beckett/TEFFRA 	<ul style="list-style-type: none"> • Face-to-face interview is waived • Allowing self-attestation of verification requirements except U.S. citizenship and eligible immigration status 	<ul style="list-style-type: none"> • Allowing self-attestation of verification requirements except U.S. citizenship and eligible immigration status



Preparing for the Unwinding of the PHE and the Return to Normal Operations is One of DHCF’s Priorities in 2022



- Today’s focus is on returning to normal eligibility operations – but there are other program elements (both operations and payment) that will be effected when the PHE concludes
- Returning to normal eligibility operations is a significant effort and will require support across DHCF, other District agencies, MCOs, providers, and other stakeholders
- CMS guidance on unwinding has been issued throughout the PHE
 - We are relying on the most recent guidance, State Health Official (SHO) Letter #22-001, to guide our current planning efforts

PHE and Emergency Authorities for the Medicaid Program

Authority	Effective Date	Termination Date	Example
Medicaid disaster relief/emergency SPA template for the COVID-19 PHE	March 1, 2020, or any later date elected by the state	End of the federal PHE (including any extensions), or any earlier date elected by the state	DC SPA 20-001 : Temporary 20% increase to nursing facility rates
Appendix K (used for home and community based services waivers)	January 27, 2020, or any later date elected by the state	Up to six (6) months following the conclusion of the federal PHE (including any extensions)	1915(c) HCBS Waiver Appendix K : Temporary 15% increase to assisted living facility rates
Medicaid 1135 Waivers	March 1, 2020	End of the federal PHE (including any extensions)	District 1135 Waiver Request : Temporarily suspend Medicaid fee-for-service prior authorization requirements



Overview of CMS Guidance and Expectations on Returning to Normal Eligibility Operations



CMS 3/3/22 SHO Letter #22-001 expands on the previously issued 8/13/21 SHO letter on unwinding planning with a focus on 3 keys areas

- Describe how states may distribute eligibility and enrollment work to restore routine operations
- Mitigate churn for eligible beneficiaries
- Promote smooth transition of individuals between coverage programs including marketplaces

Unwinding of the Federal PHE means a return to routine Eligibility Operations:

- Requires completion of redeterminations for all Medicaid beneficiaries
- Beneficiaries required to report changes and the agency to act on system known changes and reported changes
- Agency may termination coverage for beneficiaries who are determined no longer eligibility for Medicaid or does not return requested information.

Renewals

- States have 12 months to initiate all renewals redeterminations and an additional 2 months to complete all pending actions (14 months)
- CMS Guidance provided states three options to begin the 12-month unwinding period.
- The District selected Option C: begin 12-month unwinding period the month after the end of the PHE



CMS Unwinding Chart Flow Options

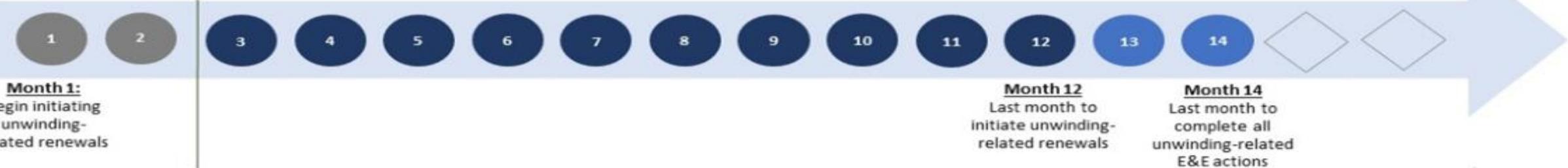
CMS Flow from SHO Letter



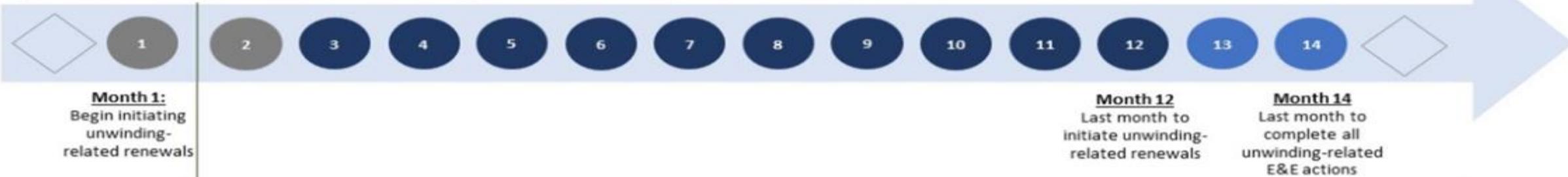
End of PHE
End of the Month in Which the PHE Ends

States only initiating renewals
 States initiating and completing renewals
 States only completing renewals
 12 month unwinding period
 No unwinding-related E&E actions

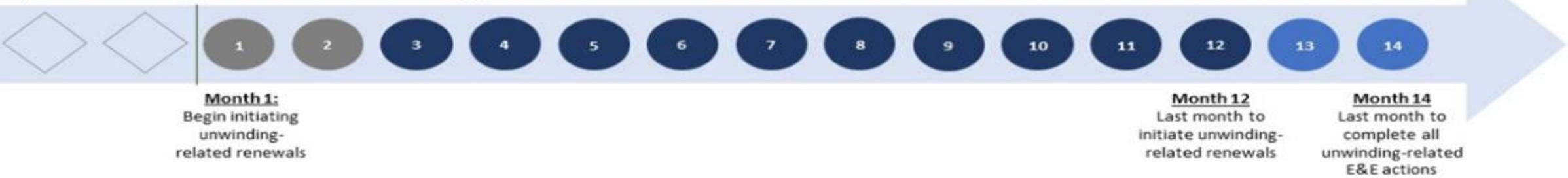
Option A: State begins 12-month unwinding period two months prior to the end of the PHE



Option B: State begins 12-month unwinding period one month prior to the end of the PHE



Option C: State begins 12-month unwinding period the month after the PHE ends





1902(e)(14)(A) Waivers



- CMS guidance provided new waiver options under (e)14(A) authority to allow states more flexibility as part of unwinding efforts.

Options

1. Time extension on Administrative Action and Fair Hearing
2. Ex-Parte/Passive renewal for individuals with no income/data returned from electronic sources if renewal or initial application completed in the past 12 months.
3. Accept MCOs updated beneficiaries contact information received by the plans
4. Extend the automatic Managed Care plan reenrollment period from 60 to 120 days. District selected 90 days.



Operational Planning Efforts Underway



- In preparation of the end of PHE, some of DHCF's key readiness actions in the following:
 - Reviewing and drafting policy revisions and changes to verification plan and transmittals
 - Assessing operational and staffing needs and impact
 - Evaluating staff training needs
 - Working closely with DCAS administration for system readiness and training
 - Evaluating outreach needs for stakeholders/public and implementation of outreach/communication plan



Key Strategies for Working with Managed Care Plans



- As states return to normal operation, a collaboration between States and the Managed Care Organization (MCO) will help ensure beneficiaries retain Medicaid coverage and ease the transition for individuals.

Strategy #1: *Partner with Plans to obtain and update Beneficiary Contact Information*

Strategy #2 *Share Renewal Files with Plans to Conduct Outreach and Provide Support to Individuals Enrolled in Medicaid during their Renewal Period. There are two approaches outlined in the guidance.*

Strategy #3 *Enabling Plans to Conduct Outreach to Individuals Who Have Recently Lost Coverage for Procedural Reasons*

Strategy #4 *Permitting Plans to Assist Individuals to Transition to and Enroll in Marketplace Coverage if Ineligible for Medicaid and CHIP*



Presentation Overview



- **Background on Medicaid Policy During Federal PHE**
- **Eligibility Changes and Operations Related to the PHE**
- **Long Term Care Changes Related to the PHE**



The District has several current PHE-related flexibilities that impact LTC



- Waiver of “wet” physician/APRN signature on POF requesting initial assessment and reassessments; physician assent to submit is still required
- Conduct of long-term care assessments through remote, web-based or telephonic means
- Waiver of physical beneficiary signature on LTC applications for EPD waiver renewals, assessment, PCSP documentation, plans of care, and other forms, with attestation of beneficiary consent
- Extension of Medicaid eligibility for up to twelve months from the previously established eligibility end date
- Suspension of adverse authorization actions, including reduction or termination of benefits, except in cases of beneficiaries unable to participate in services or rejecting care / declining services
- Conduct of person-centered service planning, monthly visits, and any other care coordination visits by service coordinators, case managers, Services My Way (SMW) support brokers, and home health agencies’ supervisory nursing staff through HIPAA-compliant remote, web-based or telephonic means



The District has several current PHE-related flexibilities that impact LTC



- Hiring flexibility to employ DC, MD, and VA CNAs to provide personal care services (adoption of DC Health flexibilities). This did not de-obligate providers from ensuring individual aides possess an NPI and were enrolled and affiliated in PDMS
- Payment flexibilities for home health (personal care aide, PT, OT, ST, PDN) services facilitating additional staffing, overtime pay and other mechanisms to address potential workforce shortages
- Enhanced NF and ALF payments
- Enhanced payments / payment flexibilities for DDS providers
- Payment flexibilities for ADHPs to facilitate conduct of some ADHP services through HIPAA-compliant remote, web-based or telephonic means, or to pay retainer payments when services cannot be rendered
- Remote oversight and monitoring visits for provider compliance
- Deferment of or remote site visits conducted as a part of provider enrollment / reenrollment



Although the federal PHE is on-going, DHCF is planning for when PHE-related flexibilities end



- DHCF generally sought to adhere to some guiding principles in post-PHE planning:
 - Minimization of felt impacts for beneficiaries as the health care system returns to “routine” modes of operation
 - Support of health care providers to ensure continued operations and access to care for beneficiaries
 - Continuation of PHE-implemented flexibilities that yielded positive outcomes to the extent allowable under current Medicaid authorities
- Additional guidelines to keep in mind:
 - DHCF welcomes provider and stakeholder feedback on communications, engagement, and process of unwinding
 - At this time, there is no date certain for the end of the federal PHE; we will continue to provide updates as we receive guidance from CMS



Questions/Feedback